GLOSSARY

School-based Medicaid and other services: Terms to know to help improve children's access to healthcare

Note: This document defines and briefly explains the key terms to know when discussing school-based Medicaid, other health services and the federal change in the "free care rule." For a webinar or presentation that contextualizes these terms, please contact childhealth@aft.org.

504: Section 504 of the Rehabilitation Act of 1973 is also incorporated into the Americans with Disabilities Act. This section of federal law, enforced by the Office for Civil Rights within the U.S. Department of Education, asserts that students are entitled to a "free and appropriate education (FAPE)" regardless of the nature or severity of any disability. Learn more.

ACA: The Patient Protection and Affordable Care Act of 2010, or ACA, is the national healthcare law known as "Obamacare." This federal legislation changed many aspects of the U.S. healthcare system, including ensuring that more children have health insurance through Medicaid and the Children's Health Insurance Program (CHIP) and facilitating a transition to a managed care financing structure, which seeks to curb high costs. Learn more.

ADA: The Americans with Disabilities Act first passed in 1990. This "equal opportunity" law for people with disabilities is modeled after the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Several U.S. Department of Education offices enforce this law on behalf of students with disabilities. Learn more.

Administrative claiming: States can use federal Medicaid funds for activities found necessary "for proper and efficient program administration." Specific services, however, must be approved in the state's Medicaid state plan to be reimbursed. For example, schools and districts may seek reimbursement for the costs associated with translation services or enrolling children in public insurance programs. To submit claims for these services, a district does not need to complete the process to become a qualified Medicaid provider, so it may be easier to participate in this kind of Medicaid claiming. Of note, states define "administrative services" differently. As an example, case management is considered an administrative service in some places (e.g., Illinois) and a health service in others (e.g., New York). Learn more.

CHIP: The Children's Health Insurance Program was established by Title XXI of the Social Security Act. The program enrolls more than 8 million children in Medicaid and separate CHIP programs and ensures access to the (fairly comprehensive) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Learn more.

CMS: The Centers for Medicare & Medicaid Services within the U.S. Department of Health & Human Services oversees Medicare, Medicaid, the Children's Health Insurance Program and the health insurance marketplace. Nearly all federal guidance for school-based Medicaid comes from CMS, though it does not currently have a dedicated "home" for school-related concepts. CMS regional offices further interpret federal guidance and more directly liaise with state Medicaid agencies, such as for Medicaid state plan amendments. Learn more.

EPSDT: Every beneficiary from birth to age 20 enrolled in Medicaid and CHIP programs is entitled to Early and Periodic Screening, Diagnosis and Treatment services necessary to control, correct or reduce health challenges. Traditionally, the free care rule has been a serious barrier to offering EPSDT services in school settings. The free care rule and other barriers led the Centers for Medicare & Medicaid Services to conclude in 2014 that "children's participation in EPSDT medical screenings remained lower than established goals," which of course impacts their use of covered diagnosis and treatment services, as well. Learn more.

ESSA: In 2015, Congress reauthorized the federal Elementary and Secondary Education Act under the name the Every Student Succeeds Act, which replaces the last version of this federal law, commonly known as No Child Left Behind. Most notably, ESSA (1) limits the federal government's role in many elements of education policy, and (2) ends the use of many punitive levers that tried to hold low-performing states, districts and schools accountable under NCLB. There are several spaces in the law to pursue health promotion for both students and staff, including allowable uses of Title I funding for high-poverty schools, Title II funding for staff and faculty training, and Title IV, which largely combines formerly separate health and wellness initiatives into a block grant. Learn more.

FFP: The Social Security Act requires federal financial participation rates to be determined each year, which set the federal medical assistance percentage (FMAP) to match state funds in Medicaid reimbursements and costs. The federal government generally covers at least half of state costs, and the rate of FFP is determined by state poverty rates. Learn more.

FFS: For many years, the U.S. healthcare system has relied on fee-for-service financing, in which healthcare providers receive reimbursement for each service offered, such as an office visit, test or procedure. If a state uses a fee-for-service model for reimbursement in some or all parts of its Medicaid program, provider rates are detailed in the state Medicaid plan. Learn more.

FQHC: The Health Resources & Services Administration within the U.S. Department of Health & Human Services oversees federally qualified health centers—organizations receiving grants under Section 330 of the Public Health Service Act and required to offer health services to the underserved. FQHCs may

submit claims for beneficiaries of Medicare, Medicaid and CHIP, and they generally enjoy significantly higher reimbursement rates than healthcare providers that accept public insurance. Partly for this reason, FQHCs are popular sponsors of school-based health centers. Learn more.

Free care rule: In an effort to guide schools and districts in leveraging relevant public insurance, the Centers for Medicare & Medicaid Services established the free care rule. It effectively stated that if a health service was provided without charge to some in the school community, Medicaid reimbursement could not be sought for the same service provided to a Medicaid-eligible student. An important exception to the rule was for health services provided to a Medicaid-eligible student that were also codified in the student's Individualized Education Program. In December 2014, CMS changed its stance: Regardless of how schools and districts finance the healthcare services provided to other children, Medicaid reimbursement can now be sought for healthcare services provided to Medicaid-eligible students (assuming all other federal and state Medicaid requirements are met). Learn more.

GAO: The Government Accountability Office, which investigates how the federal government spends taxpayer dollars, has released several reports that consistently illuminate the challenges, impact and potential of school-based Medicaid claiming. Some examples include "Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services" (2010), "Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight" (2000), and "Medicaid and Special Education: Coordination of Services for Children with Disabilities Is Evolving" (1999). Learn more.

HSPF: In January 2016, the secretaries of the U.S. Department of Education and the U.S. Department of Health & Human Services jointly launched "Healthy Students, Promising Futures" with a "Dear Colleague" letter and toolkit for state agencies interested in working to promote student health. With five high-impact strategies, the toolkit explicitly encourages states to examine the change in the federal free care rule to ensure students have improved access to care. In July 2016, the departments launched a learning collaborative to promote action in select states. Learn more.

IDEA: The Individuals with Disabilities Education Act, first passed in 1975, ensures that children with disabilities have the opportunity to receive a free, appropriate public education. Part B covers school-age children and guides the Office of Special Education Programs within the U.S. Department of Education. Under this federal law, the accommodations and services required for a given student with a disability are codified in an Individualized Education Program. If the IEP for a Medicaid-eligible student lists a health service, Medicaid reimbursement has generally been allowed because, according to the statute, IDEA funds "shall not be used to pay costs that otherwise would be reimbursed" under Medicaid. Learn more.

IEP: Under the Individuals with Disabilities Education Act of 1975, the accommodations and services required for a given student with a disability that interferes with the student's education and performance are codified in an Individualized Education Program. Health services listed in the IEP of a Medicaid-eligible student have always been exempt from the free care rule. An IEP may specify, for

example, that a child is entitled to speech-language pathology, social work, mobility or counseling services. A student with an IEP is also protected under all Section 504 laws. Learn more.

IHP: Under Section 504 of the Rehabilitation Act of 1973, which is also incorporated into the Americans with Disabilities Act, the accommodations and services required for a given student with a disability that substantially limits at least one major life activity, such as walking, writing, speaking or eating, are codified in an Individual Health Plan, also called a 504 plan. An IHP may specify, for example, that a child is entitled to a scribe, preferential seating, extended time limits or unlimited bathroom breaks. A student with an IHP is not necessarily protected under IDEA. Learn more.

MCO: The Patient Protection and Affordable Care Act encourages a nationwide transition away from a fee-for-service model of healthcare funding and toward payment for effective performance. One key strategy in a "pay for performance" approach is the managed care organization, designed to reduce cost and utilization while improving care quality by accepting a set per-member-per-month (capitation) payment for all services rendered. The MCO is then responsible for controlling cost within its capitated funding, such as by investing in more prevention and reducing the need for expensive, late-stage interventions. To date, few schools or districts have been successfully integrated into the MCOs of their state or region, but such integration may be a sustainable way to organize school-based health services in the 21st century, especially as the nation nears its aim to finance about 4 of 5 health interactions through managed care by 2020. Learn more.

Medical necessity: Generally, health services must be medically necessary—deemed reasonable, necessary, specific, effective and skilled, per the Medicaid state plan—in order to be eligible for Medicaid reimbursement. In the case of services provided to youth from birth to age 20, a service should meet a more inclusive threshold to "correct, control or ameliorate" a health condition. Still, many school-based health services have been subject to the more stringent requirement. Both definitions have traditionally made it difficult to justify reimbursement for health services that seek to avoid or reduce risk; consider homelessness, a risk factor for various illnesses, though not a diagnosable health condition on its own. Additionally, demonstrating that a health service is medically necessary for a given child can make it difficult to seek reimbursement for group-based services, such as talk therapy. Learn more (example is specific to school-based speech pathology).

OSEP: Within the U.S. Department of Education, the Office of Special Education Programs is a component of the Office of Special Education and Rehabilitative Services (OSERS). OSEP uses grants authorized under the Individuals with Disabilities Education Act to support states and institutions of higher education in their work to serve children and youth with disabilities through age 21. Learn more.

RMTS: Per federal guidance, state Medicaid programs must use a CMS-approved allocation methodology to account for 100 percent of personnel's time (including time spent engaging patients without Medicaid eligibility or coverage). Methods may include a Random Moment Time Study, contemporaneous time sheets or other quantifiable measures of employee effort. In 2000, the GAO

highlighted RMTS as more accurate than representative period or continuous log methods, and RMTS has become more common among school-based Medicaid programs.

Typically, in an RMTS model, randomly selected participating providers across the state system receive notice that they must submit data on "moments" or encounters with students that answer questions such as:

- Who were you with?
- What were you doing?
- Why were you doing that activity?

Responses are required within a standard time frame, and the data are used to estimate the proportion of activities eligible for Medicaid reimbursement. Learn more.

SBHC: School-based health centers are strategic partnership models that seek to improve students' access to healthcare, including primary care, oral health, counseling, reproductive health, health education and more. SBHCs are generally sponsored by federally qualified health centers, local private health providers, local health departments or school districts. For those SBHCs that are sponsored by governmental entities, the federal change in the free care rule is especially exciting because the shift means that expanding SBHCs in new districts and schools is a more financially sustainable proposition. Learn more.

SISP: Two federal laws, the Individuals with Disabilities Education Improvement Act (2004) and the Every Student Succeeds Act (2015), include the term specialized instructional support personnel. Often, these school staff—such as counselors, nurses, occupational therapists, physical therapists, psychologists, social workers and speech-language pathologists—offer assessment, diagnosis, counseling, educational, therapeutic and other services to meet the needs of the whole child. Learn more.

SPA: When a state is planning to make a change to its program policies or operational approach, it must send a state plan amendment to the Centers for Medicare & Medicaid Services for review and approval. States also submit SPAs to make corrections or update their Medicaid or CHIP state plan with new information. Submitted state plan amendments are searchable through a CMS database. Learn more.

TPL: In an effort to guide schools and districts in leveraging relevant public insurance, the Centers for Medicare & Medicaid Services established the concept of third party liability. For Medicaid beneficiaries who also receive insurance coverage from another source, that other coverage provider has a legal responsibility to pay its share *before* Medicaid. If all expenses are not covered by the other party, Medicaid may cover the remainder of the claim as the "payer of last resort." Learn more.